Audit Report
Electronic Screening of Claims Paid by New West
January,1 2012-December,31 2012

Prepared Under Contract With:
MONTANA LEGISLATIVE BRANCH, AUDIT DIVISION
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The Legislative Audit Committee
of the Montana State Legislature:

Enclosed is the report on the audit of the medical and dental claims for the state of Montana employee benefits plans for the year ended December 31, 2012.

The audit was conducted by Claim Technologies Incorporated under a contract between the firm and our office. The comments and recommendations contained in this report represent the views of the firm and not necessarily the Legislative Auditor.

The agencies' written responses to the report recommendations are included in the back of the audit report.

Respectfully submitted,

/s/ Tori Hunthausen

Tori Hunthausen, CPA
Legislative Auditor

13C-09

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ELECTRONIC SCREENING REPORT

The State of Montana Medical Plans
Administered by:
New West Health Services
Audit Period: January 1, 2012 – December 31, 2012

Prepared: February 20, 2014

ELECTRONIC SCREENING REPORT

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Overview

Electronic Screening Objective

The objective of our electronic screening is to identify and quantify claim administration system problems that appear to be causing payment errors.

Electronic Screening Scope

CTI performed electronic screening of 100 percent of each of the medical service lines that comprise a medical claim processed by New West Health Services (New West) during the 12 month period of January 1, 2012 – December 31, 2012 (plus any run-out claims processed through September 30, 2013). New West processed 49,028 claims (including adjustments) for 4,325 State claimants representing 110,122 separate medical service line items and resulting in $13,770,984 in payment by the plan.

A complete list of the ESAS® Screening Categories and Subcategories is shown in Figure 1. below.

Figure 1.

ESAS® Screening Categories to Identify Potential Amount at Risk				
Category	**Subsets**	**Evaluate Procedure**	**Quantify Errors**	**Reason Codes**
Duplicate Payments to Providers and/or Employees				
	Duplicates from two Claims	☑	☑	DP2A-D
	Duplicates from three or more Claims	☑	☑	DP3C
Plan Limitations				
	Specific to Plan Provisions such as: • Dollar Limitations • Number of Visit Limitations	☑	☑	PLxx
	Payments After Timely Filing Limit	☑	☑	TFLM
Plan Exclusions				
	Specific to Plan Provisions such as: • Hearing Aids • Cosmetic Surgery • Weight Loss Treatment • Dental • Nutritional Counseling •	☑ ☑ ☑ ☑ ☑	☑ ☑ ☑ ☑ ☑	EXxx DXxx
Multiple Surgical Procedures				
	Multiple Procedures Should be Reduced Fees	☑	☑	MSPC

Electronic Screening Methodology

CTI used its proprietary software, ESAS®, to screen each medical service line processed. ESAS® applies several hundred screening parameters to each line to identify claims that may be paid in error. Any service line edited by ESAS® is considered "red-flagged", meaning it has the potential for having been over- or under- paid based on the screening parameters set into ESAS® and the claim data provided by the claim administrator.

To validate ESAS® screening findings, CTI selects a targeted sampling from the "red-flagged" service lines to test. This is the targeted sampling component of our electronic screening process. Our experience has shown that this type of sampling is necessary in order to validate that the claim data provided was adequate to produce reliable screening results. While CTI is confident in the accuracy of our electronic screening results, it is important to note that the dollar amounts associated with the electronic screening results shown below represent potential, not actual, overpayments and process improvement opportunities. Additional testing of these claims by New West and the State would be required to substantiate the findings and to provide the basis for remedial action planning.

CTI is not authorized to tell the Claim Administrator to recover overpaid amounts. The process and impact of recovering overpayments should be discussed by the Plan Sponsor and the Claim Administrator. If recovery is not pursued, these findings still represent the opportunity for future savings if systems and procedures can be improved to eliminate future similar payment errors.

Procedures Followed

The specific procedures that were followed to complete this electronic screening and analysis of claims data for the State are as follows:

- **Document Review**

  We conducted an in-depth review of the State administrative services agreement and plan documents. These documents provided the specifications we used in setting the parameters in ESAS® and analyzing the electronically screened results.

- **Data Conversion**

  We converted claims data provided by New West into ESAS® database formats. The converted data was reconciled against control totals and checked for reasonableness before proceeding with electronic screening.

- **Electronic Screening**

  To the extent the claim data provided to us by New West supported the ESAS® algorithms, we utilized ESAS® to screen the State Plans claims data.

- **Auditor Analysis**

  If the category represented Potential Amounts at Risk and the amount "red flagged" within that category was material, our auditors reviewed the category findings to confirm that the electronically screened potential errors appeared valid

and to select the best examples of potential overpayments to conduct further substantive testing of.

- **Substantive Testing and Additional Analysis**

  For this State audit a total of 20 red flagged cases were selected and Substantive Testing Questionnaires were prepared for each and sent to New West for completion. A CTI auditor reviewed New West's questionnaire responses and supporting documentation. Copies of New West's responses to the questionnaires are provided in Exhibit A. (Questionnaire responses presented in Exhibit A. have been redacted to eliminate personal health information.)

  Based on the responses from New West and further analysis of the ESAS® findings in light of those responses, CTI removed any false positives that could be systematically identified from the Potential Amounts at Risk. False positives typically occur because certain claim data was misleading or inadequate.

- **Review of Preliminary ESAS® Findings and Reporting**

  We reviewed the preliminary findings from the electronic screening and analysis process with the Claim Administrator to ensure that we had complete understanding and agreement (where possible) on the reported results before preparing this report.

Findings by Screening Category

This section of the report includes the ESAS® Summary report showing by category the number of line items or claims and the total potential amount at risk that remain now at the conclusion of our analysis and substantive testing protocols.

Following the ESAS® Summary report is a detailed explanation of our Substantive Testing results, findings and recommendations if it is our opinion that process improvement or recovery/ savings opportunities exist.

Note: If CTI is making an improvement recommendation, it will be denoted by a “Yes” in the final column of the ESAS® Summary reports.

ESAS - Summary (as of 01/30/2014)

Categories for Potential Amount At Risk

Client: Montana State - New West
Screening Period: 01/01/2012 - 12/31/2013

Analysis Final Results

Claims Red Flagged	609
Claimants Red Flagged	383
Paid Amount Red Flagged	$79,353
Potential Amount at Risk:	$56,049

Category	Lines	Clmts	Description	Charge Amount	Paid Amount		Potential Amount At Risk	Improvement Recommended
Duplicate Payments to Providers and/or Employees								
DP2C	**96**	**19**	**Duplicate Payments to Providers and/or Employees**	**$7,207**	**$12,700**	*	**$5,493**	**Yes**
DP2D	**14**	**4**	**Duplicate Payments to Providers and/or Employees**	**$1,015**	**$1,826**	*	**$812**	**Yes**
Plan Limitations								
PL02	113	4	2012 Outpt Rehabilitative Services 30/CY	$2,535	$1,695		$1,733	
PL06	**170**	**76**	**Routine Gyn Exam for Women 1 per Benefit Year**	**$24,963**	**$20,278**		**$20,252**	**Yes**
PL12	2	1	Mammogram once between ages 35 and 39	$239	$215		$215	
TFLM	47	19	Timely Filing (Last service date to received date)	$16,263	$3,802		$3,802	
Plan Exclusions								
EX15	10	4	Hearing Exam	$2,077	$1,020		$1,020	
EX17	1	1	Cochlear Implants, Analysis, Programming, Devices	$150	$0		$0	
EX19	119	112	Vision Refractions	$3,066	$2,646		$2,646	
EX23	5	3	Routine Foot Care (OK Diabetic/Vascular Insufficiency)	$260	$129		$129	
EX24	11	8	Orthotics (Testing & Training)	$950	$570		$570	
EX25	59	44	Orthotics	$9,966	$4,176		$4,176	
EX26	12	12	Arch Supports	$530	$239		$239	
EX28	1	1	Abortions, Elective	$518	$381		$381	
EX38	93	8	Impotency	$4,913	$2,528		$2,528	
EX53	2	1	Biofeedback	$639	$607		$607	
EX57	1	1	Recreational Therapy	$404	$364		$364	
EX63	119	72	Physicals, Work, Insurance, School	$8,173	$4,199		$4,199	
EXCE	1	1	Nose Surgery--disguise plastic surgery as Med. Nec.	$3,311	$1,216		$1,216	
Multiple Surgical Procedures								
MSPC	35	14	Multiple Surgical Procedures Should be Reduced Fee	$37,449	$23,309		$5,667	

* The amount detailed is based on Benefit Total, which equals Coinsurance + Copayment + Deductible + Paid

Categories for Operational Review

Client: Montana State - New West
Screening Period: 01/01/2012 - 12/31/2013

Analysis Final Results

Claims Red Flagged	39,709
Claimants Red Flagged	4,062
Paid Amount Red Flagged	$12,661,834
Potential Amount at Risk:	$578,629

Category	Lines	Clmts	Description	Charge Amount	Paid Amount	Potential Amount At Risk	Improvement Recommended
Duplicate Payments to Providers and/or Employees							
DP1C	**14**	**7**	**Duplicate Payments to Providers and/or Employees**	**$2,683**	**$4,581 ***	**$1,898**	**Yes**
Fraud, Waste, and Abuse							
LGEE	16	12	Large Payments Direct to Employees	$4,836	$3,216		
NCST	8	4	Unnecessary Nerve Conduction Studies	$5,040	$1,653		
ULPC	22	19	Invalid Procedure Codes	$0	$199,438		
Subrogation/Right of Recovery from Third Party							
SBxx	6145	873	Subrogation/Right of Recovery from Third Party	$1,682,693	$1,090,364		
Workers' Compensation							
WCxx	**680**	**108**	**Workers Compensation**	**$309,523**	**$208,831**		**Yes****
Coordination of Benefits							
CB01	**313**	**77**	**Paid Primary Should be Secondary to Other Group Insurance**	**$46,311**	**$23,409**		**Yes****
MCRP	552	81	Retired Employee, Plan Should be Secondary to Medicare	$53,415	$6,345		
Denial of Mandated Benefits							
DE01	1	1	Denied, Possible Self-Inflicted Injury	$15	$0	($15)	
Large Claim Review							
CMLG	4689	15	Claimants over $100,000	$3,812,787	$2,757,426		
Case Management							
CMxx	3055	323	Case Management	$595,277	$399,354		
Provider Discounts and Fees							
UI80	230	128	In-Network UCR at 80th, at 5.00 tolerance	$101,012	$69,649	$38,328	
UO80	5	4	Out-of-Network UCR at 80th, at 5.00 tolerance	$2,242	$1,624	$155	
PDSC	70122	3821	PPO Provider and No Discount Taken	$15,873,071	$10,909,497		
PPCO	1009	154	Non-PPO Provider with Incorrect Copayment	$163,984	$140,051		
Dependent Child Eligibility							
GCxx	490	34	Payments for Ineligible Grandchildren	$76,768	$47,327	$47,327	
OVxx	4465	327	Payments for Over Age Dependents	$807,767	$490,936	$490,936	

* The amount detailed is based on Benefit Total, which equals Coinsurance + Copayment + Deductible + Paid

**** Please refer to Exhibit A - Substantive Testing Questionnaire Responses and CTI Conclusions for additional detail on the categories of Workers' Compensation and Coordination of Benefits findings.**

Duplicate Payments

OBJECTIVES: To identify provider services paid more than once. Further, to identify procedural deficiencies of the administrative process and to quantify conservatively the additional cost to a plan caused by duplicate payments.

Initial Screening and Analysis

Electronic screening of all service lines processed revealed certain service lines to have potentially been paid more than once, resulting in a benefit total (the accumulation of payment, deductible and coinsurance applied to the out of pocket accumulation) greater than the charged amount for that service. Further analysis of the service lines flagged confirmed the potential for process improvement and overpayment of claims to be sufficiently material to warrant further testing.

Substantive Testing

Substantive Testing Questionnaire (QID) numbers 1- 3 were sent to New West which responded to all questionnaires submitted. Copies of the responses are provided in Exhibit A.

Substantive Testing results are shown in the following report entitled: "Substantive Testing Detail Report – Duplicate Payments".

The results confirmed the potential for process improvement and overpayment of claims.

Recommendation(s)

In the category of Duplicate Payments, after removal of any cases that New West was able to document as not having been overpaid, the following recommendations are made:

1. **Recovery Opportunity -** $8,203 on 30 claimants involving 124 lines of service. Discussion should be had with New West regarding focused audit to determine recovery potential on these service lines.

2. **Process Improvement Opportunity -** New West's system edits should be reviewed to determine if further refinement would allow for further reduction in the number of overpaid claims.

Substantive Testing Detail Report
Duplicate Payments

Client: State of Montana New West Medical
Audit Period 1/1/2012 - 12/31/2012
Questionnaire ID Numbers: 1 - 3 (See Exhibit A. – Substantive Testing Questionnaire Responses)

QID No:	Flag Type	Flag Description	Overpaid Amt	New West Response (For full response see questionnaire in Exhibit A)
1	DP1C	Service line paid twice within same claim number	$0.00*	Disagree, provided documentation to show service line is not a duplicate
2	DP2C	Service line paid twice on separate claim numbers	$5,754.35*	Agree to error
3	DP2C	Service line paid twice on separate claim numbers	$114.65*	Agree to error

*Potential overpayments that were tested and determined to not be overpaid have been removed from total potential overpaid, however other cases identified by ESAS® cannot be removed without further investigation.

Plan Limitations

OBJECTIVES: To identify services that have exceeded plan limitations on quantity, frequency or benefit amount. Further, to identify procedural deficiencies in the administrative process and to quantify conservatively the additional cost to a plan caused by payments in excess of the plan limitations.

Initial Screening and Analysis

Electronic screening of all service lines processed revealed no service lines to have been overpaid as a result of exceeding the plan's limitations.

Substantive Testing

Substantive Testing Questionnaire (QID) numbers 4 – 7 were sent to New West. New West responded to all questionnaires submitted. Copies of the responses are provided in Exhibit A.

Recommendation(s)

In the category of Plan Limitations, after removal of any cases that New West was able to document as not having been overpaid, the following recommendations are made:

Limitation Subcategory	Potential Recovery Amount	# of Claimants	Recovery/Process Improvement Opportunity
Routine Gyn Exam for Women 1 per benefit year (PL06)	$20,252	76	Discussion should be had with New West regarding a focused audit to determine recovery potential on these claims and discern if any other claims exceeded this plan limitation.

Substantive Testing Detail Report
Plan Limitations

Client: State of Montana New West Medical
Audit Period 1/1/2012 - 12/31/2012
Questionnaire ID Numbers: 4 - 7 (See Exhibit A. – Substantive Testing Questionnaire Responses)

QID No:	Flag Type	Flag Description	Overpaid Amt	New West Response (For full response see questionnaire in Exhibit A)
4	PL02	2012 Outpatient Rehabilitative Services 30/CY	$0.00*	Disagree, provided documentation to show limitation was not exceeded
5	PL06	Routine Gyn Exam for Women 1 per Benefit Year	$133.83*	Agree, limitation was exceeded
6	PL13	Mammogram one every 24 months between ages 40-49	$0.00*	Disagree, provided documentation to show limitation was not exceeded
7	PL14	Mammogram one every 12 months ages 50 and over	$0.00*	Disagree, provided documentation to show limitation was not exceeded

Exhibits

A. Substantive Testing Questionnaire Responses and CTI Conclusions

B. New West Final Response to Working Draft Report

Exhibit A.

Substantive Testing Questionnaire Responses and CTI Conclusions

Duplicate Payments to Providers and/or Employees

Substantive Testing Questionnaire

Questionnaire ID:	1
Client:	Montana State - New West
Audit Period:	01/01/2012 - 12/31/2013

The above referenced individual was identified by ESAS® as having potential duplicate claim payments.

The claims listed below appear to be duplicates. For each claim, please provide the following:

1. A copy of your administrative procedures used in identifying and preventing duplicate claim payments.

2. A copy of each bill.

3. If the listed claim(s) are duplicates, provide documentation that the overpayment has been refunded and credited to the client's account.

Administrator's Response

Notes in 837 file indicate separate antigens.

~SV1*HC:95165*510*UN*48***1~DTP*472*D8*20120625~REF*6R*00028~NTE*ADD*48 DOSES POLLENS~

Conclusion

No procedural deficiency has been identified. Any other claim can only be considered correct when a procedure that is billed multiple times is valid.

No payment error was identified. Procedure was billed multiple times on same billing. Any other claim can only be considered correct when a procedure that is billed multiple times is valid.

Duplicate Payments to Providers and/or Employees

Substantive Testing Questionnaire

Questionnaire ID:	2
Client:	Montana State - New West
Audit Period:	01/01/2012 - 12/31/2013

The above referenced individual was identified by ESAS® as having potential duplicate claim payments.

The claims listed below appear to be duplicates. For each claim, please provide the following:

1. A copy of your administrative procedures used in identifying and preventing duplicate claim payments.

2. A copy of each bill.

3. If the listed claim(s) are duplicates, provide documentation that the overpayment has been refunded and credited to the client's account.

Administrator's Response

Duplicate claim was identified by New West during audit of new processor. Per notes in claim refund requested. (see additional documentation named Substantive Testing Question 2.pdf)

Conclusion

A procedural deficiency has been identified. Procedure was billed multiple times dates on different billings. Charges are duplicates. Any other claim can only be considered correct when a procedure that is billed multiple times is valid.

A $5,754.35 overpayment error has been identified. Procedure was billed multiple times on different billings. Charges are duplicates. Any other claim can only be considered correct when a procedure that is billed multiple times is valid.

Documentation was provided showing the refund has been requested, but no documentation that it has been received.

Duplicate Payments to Providers and/or Employees

Substantive Testing Questionnaire

Questionnaire ID:	3
Client:	Montana State - New West
Audit Period:	01/01/2012 - 12/31/2013

The above referenced individual was identified by ESAS® as having potential duplicate claim payments.

The claims listed below appear to be duplicates. For each claim, please provide the following:

1. A copy of your administrative procedures used in identifying and preventing duplicate claim payments.

2. A copy of each bill.

3. If the listed claim(s) are duplicates, provide documentation that the overpayment has been refunded and credited to the client's account.

Administrator's Response

Duplicate claim was identified by New West during audit of new processor. Per notes in claim refund requested. (see additional documentation named Substantive Testing Question 3.pdf)

Conclusion

A procedural deficiency has been identified. Procedure was billed multiple times dates on different billings. Charges are duplicates. Any other claim can only be considered correct when a procedure that is billed multiple times is valid.

A $114.65 overpayment error has been identified. Procedure was billed multiple times on different billings. Charges are duplicates. Any other claim can only be considered correct when a procedure that is billed multiple times is valid.

Documentation was provided showing the refund has been requested, but no documentation that it has been received.

Plan Limitations

Substantive Testing Questionnaire

Questionnaire ID:	4
Client:	Montana State - New West
Audit Period:	01/01/2012 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred claim payment(s) for conditions which are limited under this Plan.

1. The claims relating to charges for the plan limitation in question are listed below. Please provide documentation showing that the benefits for cardiac rehabiliation, occupational therapy, physical therapy, and/or speech therapy have not been exceeded based on the plan limitations.

Administrator's Response

Member received 34 of 30 physical therapy visits and 18 of 20 chiropractic visits. (see additional documentation named Substantive Testing Question 4.xls) Authorization #134703 granted an exception of 4 additional physical therapy visits. (see additional documentation named Substantive Testing Question 4.doc)

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Plan Limitations

Substantive Testing Questionnaire

Questionnaire ID:	5
Client:	Montana State - New West
Audit Period:	01/01/2012 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred claim payment(s) for conditions which are limited under this Plan.

1. The claims relating to charges for the plan limitation in question are listed below. Please provide documentation showing that the benefits for routine exam have not been exceeded based on the plan limitations.

Administrator's Response

Agree - claim paid in error. Refund requested.

Conclusion

A procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

A $133.83 overpayment error has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Documentation of the refund request was provided.

Plan Limitations

Substantive Testing Questionnaire

Questionnaire ID:	6
Client:	Montana State - New West
Audit Period:	01/01/2012 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred claim payment(s) for conditions which are limited under this Plan.

1. The claims relating to charges for the plan limitation in question are listed below. Please provide documentation showing that the benefits for mammogram have not been exceeded based on the plan limitations.

Administrator's Response

State of Montana benefit year = January through December. SHS12100009031 incurred during 2011 benefit year. EH123140000102 is billing the facility/technical component and EH123130000348 is billing the professional fee.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Plan Limitations

Substantive Testing Questionnaire

Questionnaire ID:	7
Client:	Montana State - New West
Audit Period:	01/01/2012 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred claim payment(s) for conditions which are limited under this Plan.

1. The claims relating to charges for the plan limitation in question are listed below. Please provide documentation showing that the benefits for mammogram have not been exceeded based on the plan limitations.

Administrator's Response

State of Montana benefit year = January through December. EU113330000026 incurred during 2011 benefit year. 1302200204 is billing the facility/technical component and EH123420000348 is billing the professional fee.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Plan Exclusions

Substantive Testing Questionnaire

Questionnaire ID:	8
Client:	Montana State - New West
Audit Period:	01/01/2012 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred claim payment(s) for conditions which are excluded under this Plan.

The claim(s) for the treatment in question are listed below. Please respond to the following:

1. How are claims for cochlear implants, analysis, programming or devices services identified and investigated?

2. Provide the documentation that supports the payment of these claims.

Administrator's Response

Cochlear implant was authorized for payment by Jackie Dunbar, State of Montana. . (see additional documentation named Substantive Testing Question 8.pdf)

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Plan Exclusions

Substantive Testing Questionnaire

Questionnaire ID:	9
Client:	Montana State - New West
Audit Period:	01/01/2012 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred claim payment(s) for conditions which are excluded under this Plan.

The claim(s) for the treatment in question are listed below. Please respond to the following:

1. How are claims for physicals for work, insurance, or school services identified and investigated?

2. Provide the documentation that supports the payment of these claims.

Administrator's Response

1. Claims for work, insurance or school physicals are identified and investigated based on diagnosis.

2. Claim 1305000008 was performed as an annual exam and to establish the patient with the physician (see additional documentation named Substantive Testing Question 9.pdf)

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Plan Exclusions

Substantive Testing Questionnaire

Questionnaire ID:	10
Client:	Montana State - New West
Audit Period:	01/01/2012 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred claim payment(s) for conditions which are excluded under this Plan.

The claim(s) for the treatment in question are listed below. Please respond to the following:

1. How are claims for facial reconstruction services identified and investigated?

2. Provide the documentation that supports the payment of these claims.

Administrator's Response

Services were authorized for payment by Jessica Jones, State of Montana.
Below is the message sent via secure server:
From: Jessica Jones
Date Sent: 6/20/2012 3:16:11 PM
Recipients...
Attachments:
Subject: appeal
Hi Bonnie, we are going to overturn the denial for [patient name removed], dep on [member name removed] policy [ID # removed] for [type of surgery removed]. Please have a authorization loaded to allow this service. Thanks!

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Large Payments Direct to Employees

Substantive Testing Questionnaire

Questionnaire ID:	11
Client:	Montana State - New West
Audit Period:	01/01/2012 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred material amounts of claims payments paid directly to the individual instead of the health care provider. Please provide the following information regarding this individual and attach it to this form:

1. Explain why the claim(s) listed below were paid to the individual instead of the provider.

2. Provide a copy of the entire claim(s) showing the assignment of benefits.

Administrator's Response

Services were submitted by member rather than provider. Services submitted without an assignment of benefits are reimbursed to the member rather than the provider.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Unnecessary Nerve Conduction Studies

Substantive Testing Questionnaire

Questionnaire ID:	12
Client:	Montana State - New West
Audit Period:	01/01/2012 - 12/31/2013

The above referenced individual was identified by ESAS® as having claims paid for nerve conduction studies (CPT codes 95900-95904) for a condition that would not warrant this service and/or without an accompanying needle EMG. Please provide the following information regarding this claim payment and attach it to this form:

1. Documentation of the medical necessity that supports payment of the nerve conduction studies.

2. The criteria used to determine eligibility of benefits for nerve conduction studies.

Below is the list of claims for the nerve conduction studies:

Administrator's Response

EH113610000527/EH113610000527A
Method of Contact: Verbal contact made on 12/9/2011 by Patti at Missoula Bone and Joint requesting inpatient surgical admission for SI joint stabilization spinal surgery, no specific request for nerve conduction testing was made. 12/13/2011 Clinical information received via fax and review by New West Case Management and surgical request was approved as medically necessary as evidenced by Milliman Guidelines with specifics below:

Musculoskeletal Surgery or Procedure GRG....GRG: SG-MS (ISC GRG)Surgery or other procedures covered by this guideline are indicated for 1 or more of the following... Fracture, dislocation, or other skeletal injury requiring procedure.....Fracture, dislocation, or other skeletal injury requiring procedure, including 1 or more of the following....Internal fixation.

Date/Time request processed: Request was reviewed and approved in a timely manner, authorization letters generated to member and provider on 12/16/2011.

Claim Detail: Date of service 12/14/2011, claim received 12/27/2011, Place of Service 22 (outpatient hospital) surgery was billed with intraoperative nerve testing, claim EH113610000527 processed out of network for non contracted provider. This case was taken to appeals on 6/6/2012. Claim was reprocessed in network due to hidden provider charges as member was not aware of service or non par provider during surgery. Claim was paid in network at billed charges.

EH113610000529 denied as provider not eligible.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Subrogation/Right of Recovery from Third Party

Substantive Testing Questionnaire

Questionnaire ID:	13
Client:	Montana State - New West
Audit Period:	01/01/2012 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred material amounts of claims payments for condition(s) for which investigation into the potential for Subrogation and/or the exercise of the Right of Recovery provision was warranted.

The following list of claims appear to be related to accidental injury. In some cases more than one accident may have occurred. For each accidental injury represented, please provide the following:

1. A copy of the documentation used to determine if a third party was potentially liable for the injury that resulted.

2. If Subrogation/Right of Recovery follow-up was determined to be necessary and is ongoing, provide copies of all correspondence pertaining to your initial investigation and follow-up activity to date. Note: Copies of the telephone logs should be included.

3. If Subrogation/Right of Recovery follow-up was determined not to be necessary (ie there is no third party involvement), provide copies of all correspondence pertaining to your initial investigation that allowed that determination to be made.

4. If Subrogation/Right of Recovery reimbursement has been received, provide copies of refund checks, screen prints to support that claims history for this individual has been adjusted to reflect the refund, and documentation to support that the refunds have been credited to the client's claim account.

Administrator's Response

At the time this claim processed, New West was not actively pursuing subrogation based on advice from our legal counsel.

Conclusion

The issue of third party liability investigation is currently the subject of litigation for the plan. At this time, CTI declines to opine on the actions of third-party administrators with respect to third party liability recovery.

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Workers Compensation

Substantive Testing Questionnaire

Questionnaire ID:	14
Client:	Montana State - New West
Audit Period:	01/01/2012 - 12/31/2013

The above referenced individual was identified by ESAS® as having received claim payments for conditions that may be work related and the responsibility of the individual's workers' compensation plan. Please respond to the following:

1. Was an investigation conducted to determine if the condition on the claim(s) listed below was work related?

[ ] Yes - What were the results of the investigation?
[ ] No - Explain why no investigation was conducted.

2. If found to be a work-related condition, has recovery of payments made by this Plan been initiated?

[ ] Yes - What is the status of recovery? (i.e. how much has been recovered, when was the last follow up made)
[ ] No - Explain why recovery has not been initiated.

Administrator's Response

Please see copies of claims submitted. No indication of accident or work related injury coded on claims; therefore, no investigation was performed.

Conclusion

A procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

A $169.36 overpayment error was identified as the documentation for claim number EH120310001245A shows the patient was the employee rather than the spouse. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Workers Compensation

Substantive Testing Questionnaire

Questionnaire ID:	15
Client:	Montana State - New West
Audit Period:	01/01/2012 - 12/31/2013

The above referenced individual was identified by ESAS® as having received claim payments for conditions that may be work related and the responsibility of the individual's workers' compensation plan. Please respond to the following:

1. Was an investigation conducted to determine if the condition on the claim(s) listed below was work related?

[ ] Yes - What were the results of the investigation?
[ ] No - Explain why no investigation was conducted.

2. If found to be a work-related condition, has recovery of payments made by this Plan been initiated?

[ ] Yes - What is the status of recovery? (i.e. how much has been recovered, when was the last follow up made)
[ ] No - Explain why recovery has not been initiated.

Administrator's Response

No investigation conducted as claims do not reflect any coding which would indicate services were related to work related injury.

Conclusion

A procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Paid Primary Should be Secondary to Other Group Insurance

Substantive Testing Questionnaire

Questionnaire ID:	16
Client:	Montana State - New West
Audit Period:	01/01/2012 - 12/31/2013

The above referenced individual was identified by ESAS® as having other insurance coverage indicated in the system, yet 100% of the allowed amount was paid. A sample of the claims are listed below. Please provide the following information on this individual:

1. Documentation indicating that this individual does not have other insurance coverage.

2. Provide an explanation of your procedures for determination of primary or secondary payer under Coordination of Benefits.

Administrator's Response

Claim 12219000034 processed using coordination of benefits. Other carrier entire allowed amount ($882.34) applied to deductible resulting in no payment by primary carrier. Claim EH122900000968 processed as primary erroneously, refund requested. (see additional documentation named Substantive Testing Question 16.pdf)

Conclusion

A procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

A 1,989.04 overpayment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Documentation of the refund request was provided.

Retired Employee, Plan Should be Secondary to Medicare

Substantive Testing Questionnaire

Questionnaire ID:	17
Client:	Montana State - New West
Audit Period:	01/01/2012 - 12/31/2013

The above referenced individual was identified by ESAS® as being eligible for Medicare as a Retired employee over age 65. There is no primary insurance coverage indicated in the data provided. Please respond to the following:

1. Is the individual a Retired employee?

___ Yes
___ No

2. Does the claim administration system reflect that Medicare is the primary insurance?

Yes - Date Medicare became primary on this individual's claims: ___/___/___

No - Provide an explanation as to why Medicare is not reflected in the system as the primary Plan.

Administrator's Response

Claims have been submitted by Montana Veterans Administration (VA). Per Summary Plan Document, when coordinating benefits with VA for Medicare eligible member, State of Montana plan pays primary.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Large Claim Review

Substantive Testing Questionnaire

Questionnaire ID:	18
Client:	Montana State - New West
Audit Period:	01/01/2012 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred a material amount of claim payment on one claim (Claim No. I-EU121320000017 with a payment of $35,557.32)

1. Please provide copies of documentation of your high dollar claim review procedures.

2. Confirm that your high dollar claim review procedures were followed on this claim by providing the date the review was completed.

3. Was case management involved on this individual at the time of this claim? If not, was case management review triggered as a result of this large individual claim?

Administrator's Response

(see additional documentation named Substantive Testing Question 18.doc)

1. Large claims can be reviewed by either the claims department or the medical services department, depending upon the reason for the review. Prospective manual review for all medical claims prior to payment is performed on all high dollar claims as described below. Review of these claims may also result in identification of a high risk diagnosis or chronic treatment needs that may result in a referral for case management as well

Manual Claims Review processes:
1. Electronic claims over $5000
2. Paper claims: institutional charges over $25,000
3. Professional charges, including dental over $10,000

In addition, the State of Montana and the University System both also require an internal claims review within the State or University agency staff for any claims that will be released in other targeted amounts and for specific scenarios, e.g. for institutional claims that exceed $50,000, unless implants are billed for State members, in which case the amount that triggers a review is $25,000.

Once a large case is identified, regardless of the method in which the case was found, large case management is performed by New West Registered Nurses, within scope of licensure practice rules. Targeted complex cases are reviewed regularly with a team of medical professionals, including the Medical Director, and Registered Nurses, to identify possible interventions or suggestions for cost containment with respect to utilization, treatment, and plans of care. This practice allows New West staff to intervene as appropriate and ensure that medically appropriate care is rendered, as well as offers the opportunity to ensure members are empowered to make informed decisions regarding health care options.

a. How are claims identified for large claim case management?
Claims are identified as noted above. Requests for utilization initiated by members and providers also offers an opportunity for New West to identify when large case management is appropriate for individual members based upon diagnoses and internal policy. The member's diagnosis is generally identified during pre-certification and/or during the internal inpatient case review process at New West, and often triggers individual case management activity.

For example, many chronic conditions that require long term, expensive treatments as per industry accepted standards (i.e., cancer) are targeted for case management, as are all patients listed for solid organ or bone marrow transplant procedures.

Access to Centers of Excellence for quality care and reduced pricing are also invoked for many of these cases as appropriate. Retrospective medical claims review can also identify cases that did not require pre-certification, however, that may be appropriate for case management, (i.e. chemotherapy treatment, dialysis, etc.) Additionally, extended inpatient lengths of stay >7 days will also trigger medical management activity.
Please see the following CASE MANAGEMENT TRIGGER DIAGNOSIS LIST that is used by New West staff as an internal guideline for identifying potential cases for medial review and/or case management.

1. Multiple trauma
   *Head and spinal cord injuries
   *Severe burns
   *Loss of limb

2. High risk obstetrical cases

3. Premature infants with an anticipated length of stay greater than one month.

4. AIDS or HIV cases receiving inpatient treatment or extensive outpatient treatment (inclusive of medications).

5. Acute life-threatening events/diseases
   *Oncology cases receiving chemotherapy and/or other therapies
   *Meningitis, viral and bacterial
   *Septicemia
6. All organ or bone marrow transplants

7. Chronic and/or debilitating disease
   *Severe pediatric anomalies
   *Neurological diseases, diseases of the spinal cord
   *Diabetes mellitus with complications
   *Renal failure, hepatic diseases, pancreatic diseases
   *Chronic respiratory diseases, severe cardiac diseases
   *Ventilator dependency

8. Home Health Care
   *Associated with an inpatient admission
   *Complex cases involving multiple disciplines
   *Potential long-term utilization, hospice
9. Long term rehabilitation
   *Quadriplegia and paraplegia
   *Cerebral Vascular Accidents

11. Chronic pain patients with frequent inpatient admissions

12. Acute or chronic psychiatric cases with repeated inpatient admission

2. High dollar claim review procedures are documented below.

8-16-2010 High dollar case reviewed by Cory Hartman and updated to State of Montana.

11-7-2011- Case review performed by Cory Hartman and State of Montana notified via large claims report.

1-11-2012 Case updates given to Sherri Rickman State of Montana.

4-24-2012 Clinical notes/ progress notes given to State of Montana

5-8-2012 Letter of Medical Necessity given to Jackie Dunbar- State of Montana as requested for review of member's high dollar treatments.

3. New West Case Management and State of Montana Case Management has worked together on this member since 2010 due to her diagnosis of [diagnosis removed], including updates and large claims reviews. Multiple Medical Director reviews have been completed in regards to her treatment plan by New West as well as SOM.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Case Management

Substantive Testing Questionnaire

Questionnaire ID:	19
Client:	Montana State - New West
Audit Period:	01/01/2012 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred material amounts of claims payments for brain tumors that Case Management review and involvement was warranted [Reference Claim Number I-EU120450000062, for example].

Please provide copies of documentation of case management activity during the audit period shown above. This documentation should include all of the following:

1. Referrals from the claims administrator to Case Management, including the date of referral.

2. All case management notes. This should include notes documenting the acceptance or rejection of the referral, ongoing clinical information, referrals to other functions such as disease management or member services and contract or other reimbursement related negotiations.

3. If reimbursement related negotiations took place, documentation showing final terms agreed to.

4. Document any charges from case management for this case. Include all supporting information.

Administrator's Response

1. This case management case was identified by the Medical Management Department during the utilization review process for an inpatient admission on 3/15/2010.

2. Case Management services began 3/22/2010; case management was involved in this case from 2010 to 6/1/2012. Including reviews for medical necessity, continuity of care and review of member's treatment plans.

3. No negotiations took place as the providers involved were contracted with New West as par or Beech Street.

4. No Case Management charges.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

PPO Provider and No Discount Taken

Substantive Testing Questionnaire

Questionnaire ID:	20
Client:	Montana State - New West
Audit Period:	01/01/2012 - 12/31/2013

The above referenced individual was identified by ESAS® as having received claim payments for services from a provider participating in a network contracted with this Plan. However, no discount was taken on the claim according to the data provided to CTI. Please respond to the following:

1. Was the provider participating in the network at the time this claim was paid?

___ Yes - Explain why a discount was not taken on this claim.

___ No - Provide documentation such as screen prints that show the provider's participation status.

Administrator's Response

Yes, provider was participating in the network at the time this claim was paid.

Allowable for procedure [code removed] = $48.00/unit
Allowable for procedure [code removed] = $93.00/unit

Provider billed less than allowable; therefore, entire billed amount allowed.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Exhibit B.

New West Final Response to Working Draft Report

NEW WEST
HEALTH SERVICES

February 18, 2014

To Whom It May Concern:

New West appreciates the opportunity to submit comment regarding the observations identified by Claim Technologies Incorporated (CTI) during their audit of State of Montana medical claims for plan year January 1, 2012 through January 31, 2012.

The first observation is associated with payment of duplicate claims. Both claims involved a less experienced employee releasing claims in error. New West used this opportunity to review the auditing and training process and has incorporated changes to diminish these errors in the future.

The second observation is associated with payment in excess of plan limitations. One claim was identified as being processed in excess of plan limitations. The member received one preventive visit from their gynecological and one preventive visit from their PCP. Based on the difference in providers and dates of service duplicate matching was not an issue; however, excess of plan limitations is. New West contacted their system vendor who supports configuration of the core claims processing system used at the time the claim was paid hoping to define the reason for the anomaly.

For both observations New West has requested refunds from providers as the then current Administrative Services Only (ASO) provider for the State if Montana. Upon receipt of the refunds, dollars will be credited to the State of Montana account following the same process used for other claims related refunds.

Sincerely;

Kathi Bahrmann

Kathi Bahrmann
Director Claims, Enrollment & Premium Billing
New West Health Services